

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of
year of birth of deceased is shown 2411 N. Charles St., Baltimore 13
FILM NO. G 95 JUN 5 1945 MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

02990218
Reg. Dist. No.

1. PLACE OF DEATH:

County Howard
City or town Brooksville Md R.F.D.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or Institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Howard
City or town Brooksville Md R.F.D. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. _____
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME

Edgar Reese Brown

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife none

7. Birth date of deceased (mo., day, yr.) Sept 14 1874 1878

8. AGE: Years 66 Months 6 Days 5 It less than one day _____ hrs. _____ min.

9. Birthplace Howard Co Md
(Town, county, and state)

10. Usual occupation none

11. Industry or business none

12. Name Henry Clay Brown

13. Birthplace Howard Co Md

14. Maiden name Annie M. Holland

15. Birthplace Howard Co Md

16. Informant Mrs. Virginia Howles

Address Brooksville Md

17. Burial Date thereof March 21 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt Carmel

Location Montgomery Co Md

18. Funeral director Ray W. Barber

Address Brooksville Md

19. 3/25 45 R.D. Bell
(Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/19 1945, at P M 3:45

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

2-24-1945 to 3-17-1945
and that I last saw him alive on 3-14-1945

Immediate cause of death

Pemphigus with
impetigo

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings:

Of operations no

Of autopsy no

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE

Chas. C. Simbleson
Bundy Spring Md M. D. of 3/19/45
Address _____ Date signed _____

PHYSICIAN

Please underline the cause to which death should be charged statistically.

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02991

Reg. Dist. No. 191

1. PLACE OF DEATH:

County HawwoodCity or town Ellisville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind County HawwoodCity or town Ellisville
(If outside city or town limits, write RURAL and give nearest town)Street No. Indiana Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Carlton Carter

3. (b) Social Security Number

4. Sex

m

5. Color or race

C

6.(a) Single, married, widowed, or divorced

single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

June 8, 1897

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

47827

hrs.

min.

9. Birthplace

Impsonville Ind.
(Town, county, and state)

10. Usual occupation

laborer

11. Industry or business

FATHER

12. Name

Wm H Carter

13. Birthplace

Ind.

MOTHER

14. Maiden name

Josephine Dorsey

15. Birthplace

Ind.

16. Informant

Mrs Josephine Carter

Address

Ellisville Ind.

17.

Burial
(Burial, cremation, or removal. Which?)

Date thereof

3-8-45
(month) (day) (year)

Cemetery or crematory

Josephine Chapel

Location

Highland Ind.

18. Funeral director

J B Higginbottom

Address

Ellisville Ind.

19.

March 7, 1945
(Date rec'd by registrar)John B. Loughman
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

March 5, 1945

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2-37-45 to 3-5-45and that I last saw him alive on 3-5-45

Immediate cause of death

Sclerosis of Lungs
(non-tuberculous)

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

B. J. Maloney

M. D. or other

Address

Calonsville Ind.

Date signed

3/5/45

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

CERTIFICATE OF DEATH

02992

Reg. Dist. No. 191

1. PLACE OF DEATH:

County HowardCity or town Elliott City
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HowardCity or town Elliott City
(If outside city or town limits, write RURAL and give nearest town)Street No. main St
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mary Charles White

3. (b) Social Security Number

none4. Sex F 5. Color or race w 6. (a) Single, married, widowed, or divorced Widow6. (b) Name of husband or wife Purnell W. White7. Birth date of deceased (mo., day, yr.) Jan. 18, 1872 8. (c) If alive, give age _____ years8. AGE: Years 73 Months 1 Days 23 If less than one day _____ hrs. _____ min.9. Birthplace Maryland
(Town, county, and state)10. Usual occupation at home11. Industry or business -12. Name James Ruckenside Clarke13. Birthplace md.14. Maiden name Anna J. Kennedy15. Birthplace md.16. Informant John W. WhiteAddress Elliott City md.17. Burial Date thereof 3-14-45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St JohnsLocation Elliott City md.18. Funeral director F. C. NigumbathanaAddress Elliott City md.19. March 14 1945 John B. Lughan
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1945 at 3 10 P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 5 1945 to March 11 1945 and that I last saw h. ex alive on March 11 1945Immediate cause of death Generalized arteriosclerosis

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Prof. L. W. W. M. D. or otherAddress Elliott City md. Date signed 3/14/45

27
BUREAU OF INVESTIGATION

UNITED STATES DEPARTMENT OF JUSTICE

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APR 6 1945

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APR 6 1945
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02993

191

Reg. Dist. No. 30

1. PLACE OF DEATH: Howard
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State.....
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Ruth
 7. Birth date of deceased (mo., day, yr.) Sept. 13, 1889 6. (c) If alive, give age..... years
 8. AGE: Years 55 Months..... Days..... If less than one day..... hrs..... min.
 9. Birthplace.....
 (Town, county, and state)
 10. Usual occupation.....
 11. Industry or business.....

12. Name.....
 13. Birthplace.....
 14. Maiden name.....
 15. Birthplace.....

16. Informant Ruth Dorsey
 Address Cooksville, Md.
 17. Burial Date thereof April 1, 1945
 (Burial, cremation, or removal, which?) (month) (day) (year)
 Cemetery or crematory Bush Park
 Location Howard Co. Md.

18. Funeral director.....
 Address 1631 Pimlico Hill Ave

19. 4/1 19 45 H.C. Andrews
 (Date rec'd by registrar) (month) (day) (year) Registrar
4-17-1945 John B. Longman,

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-29-45 19..... at 6 A. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
3-1-45 19..... to 3-29 19.....
 and that I last saw him alive on 3-29-45 19.....
 Immediate cause of death..... DURATION.....
Mitral Insufficiency?
 Due to.....
 Due to.....
 Other conditions.....

(Include pregnancy within 3 months of death)

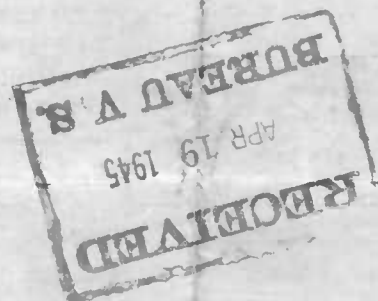
Major findings of operations..... Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?

23. SIGNATURE C. F. Maloney MD
 Address Catonsville, Md. M. D. or other.....
 Date signed 3/29/45

145 1/2 Conkora
162 1/2 Atkinson
169 Bally



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *33*

CERTIFICATE OF DEATH

02994

Reg. Dist. No. *195*

1. PLACE OF DEATH:

County *Howard*City or town *Savage*
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? *15 yrs*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md* County *Howard*City or town *Savage Md*
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

4. Sex *M* 5. Color or race *W* 6. (a) Single, married, widowed, or divorced *Married*6. (b) Name of husband or wife *Thomas A Hall*7. Birth date of deceased (mo., day, yr.) *— 1864* 6. (c) If alive, give age _____ years

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace *Upper Marlboro Md.*
(Town, county, and state)10. Usual occupation *Housewife*11. Industry or business *House*12. Name *Findings*13. Birthplace *Md*14. Maiden name *Mary Findings*15. Birthplace *Md*16. Informant *Bert J. Hall*Address *414 - 10 St. B. Shipley St.*17. *Burial* Date thereof *3/9/45*
(Burial, cremation, or removal) Which (month) (day) (year)Cemetery or crematory *St. Mary's*Location *Upper Marlboro Md.*18. Funeral director *Samuel W. D.*Address *3/9/45*19. *3/9/45* 19. *Frank Shipley*
(Date rec'd by registrar) (Registrar)

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH *March 7th 1945* at *9:30 P.*21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Dec. 1st 1944* to *March 7th 1945* and that I last saw *her* alive on *March 7th 1945*Immediate cause of death *Myocardial Infarct.* DURATION *6 hrs.*Due to *Hypertension* *3*Due to *Arteriosclerosis* *3*Other conditions *Senility* *14.*

(Include pregnancy within 3 months of death)

Major findings of operations *✓*

Date of op. _____

Autopsy results *✓*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE *Frank Shipley, M.D.* M. D. or otherAddress *Savage, Md.* Date signed *4/9/45.*

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APR 4 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02995

Reg. Diat. No. 194

1. PLACE OF DEATH:

County HowardCity or town Glenelg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HowardCity or town Glenelg
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

John David Harp

3. (b) Social Security Number

None4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Josephine E Harp

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Dec. 13 18628. AGE: Years 82 Months 3 Days 14 If less than one day _____ hrs. _____ min.9. Birthplace Frederick Co. Md.
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business

12. Name Daniel Harp13. Birthplace Md.14. Maiden name Unknown15. Birthplace Md.16. Informant Mrs. Marvin HowardAddress Glenelg, Md.17. Burial Date thereof Mar. 30, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mt. ViewLocation Alpha, Md.18. Funeral director F. C. HigginbothamAddress Ellicott City, Md.19. Mar 29 19 45 D. I. Nichols
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1945 at 8 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 1945 to March 27 1945and that I last saw him alive on March 26 1945Immediate cause of death Arteriosclerotic cardiovascular heart disease

DURATION

?

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE John K. Harp, M.D. M. D. or otherAddress Ellicott City, Md. Date signed 3/29/45

CERTIFICATE OF DEATH

TO BE FILLED BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH

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MAY 5 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 428

CERTIFICATE OF DEATH

02996

Reg. Dist. No. 194

1. PLACE OF DEATH:

County HowardCity or town Dayton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HowardCity or town Dayton
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Laisy V Hobbs

3. (b) Social Security Number

none4. Sex F. 5. Color or race W. 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Chas. V. Hobbs7. Birth date of deceased (mo., day, yr.) July 20, 1890 8. (c) If alive, give age _____ years8. AGE: Years 54 Months 8 Days 3 If less than one day _____ hr. _____ min.9. Birthplace Dayton, Md.
(Town, county, and state)10. Usual occupation at home

11. Industry or business _____

12. Name Unknown13. Birthplace "14. Maiden name "15. Birthplace "16. Informant Mrs. Gladys ShipAddress 714 Frederick Rd. Catonsville, Md17. Burial Date thereof 3-26-45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Antheum ChapelLocation Clarksville, Md18. Funeral director J. C. HigginbothamAddress Ematt City Md19. Mar 20 19 45 J. A. Nichols
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 19 45, at 2:15 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-30 19 44 to 3-22 19 45 and that I last saw h. PR alive on 3-22 19 45

Immediate cause of death _____

Carcinoma of Lungs DURATION 1 1/2 yrsDue to Carcinoma Metastatic Bladder 2 yrsDue to Cardiac Fibrillation 3 mo

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Corcoran MD M. D. or other _____Address 803 Bird Ave Date signed 3-23-45Catonsville Md

CERTIFICATE OF DEATH

1. NAME OF DECEASED (Print or Write)

2. SEX (Print or Write)

3. AGE (Print or Write)

4. DATE OF BIRTH (Print or Write)

5. PLACE OF BIRTH (Print or Write)

6. DATE OF DEATH (Print or Write)

7. TIME OF DEATH (Print or Write)

8. PLACE OF DEATH (Print or Write)

9. CAUSE OF DEATH (Print or Write)

10. SIGNATURE OF PHYSICIAN (Print or Write)

11. MEDICAL CERTIFICATION (Print or Write)

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MAY 5 1945
BUREAU V.S.

12. SIGNATURE OF REGISTRAR (Print or Write)

13. SIGNATURE OF CLERK (Print or Write)

14. SIGNATURE OF WITNESS (Print or Write)

15. SIGNATURE OF WITNESS (Print or Write)

16. SIGNATURE OF WITNESS (Print or Write)

17. SIGNATURE OF WITNESS (Print or Write)

18. SIGNATURE OF WITNESS (Print or Write)

19. SIGNATURE OF WITNESS (Print or Write)

20. SIGNATURE OF WITNESS (Print or Write)

21. SIGNATURE OF WITNESS (Print or Write)

22. SIGNATURE OF WITNESS (Print or Write)

23. SIGNATURE OF WITNESS (Print or Write)

24. SIGNATURE OF WITNESS (Print or Write)

25. SIGNATURE OF WITNESS (Print or Write)

26. SIGNATURE OF WITNESS (Print or Write)

27. SIGNATURE OF WITNESS (Print or Write)

28. SIGNATURE OF WITNESS (Print or Write)

29. SIGNATURE OF WITNESS (Print or Write)

29. SIGNATURE OF WITNESS (Print or Write)

30. SIGNATURE OF WITNESS (Print or Write)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1642

02997

CERTIFICATE OF DEATH

Reg. Dist. No. 194

1. PLACE OF DEATH:

County HowardCity or town Dayton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County HowardCity or town Dayton
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Russell O Hobbs

3. (b) Social Security Number

—

4. Sex m5. Color or race w6. (a) Single, married, widowed, or divorced widowed6. (b) Name of husband or wife Margaret O Hobbs

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 18, 19118. AGE: Years 33 Months 6 Days 14 If less than one day
hrs. min.9. Birthplace Dayton md.
(Town, county, and state)10. Usual occupation merchant

11. Industry or business

12. Name Samuel D Hobbs13. Birthplace md.14. Maiden name Warry Stevens15. Birthplace md16. Informant Mrs. C. D. HobbsAddress Dayton md.17. Burial Date thereof 3-5-45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Antithem ChapelLocation Clarksville, md18. Funeral director F.C. WeinbathamAddress Ellicott City md19. 3-4 19 md S.A. Nichols
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/2 19 45 at 7:05 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/2 19 45, to 3/2 19 45and that I last saw him alive on no date 19

Immediate cause of death

Burnshot wound in head in frontal region

DURATION

Due to instant

Due to

Due to

Other conditions none

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of 3/2/45Where did injury occur? Dayton Howard md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) homeMeans of injury gunshot - self inflicted Injured at work? no23. SIGNATURE George E. Bunting M.D.Address Ellicott City md Date signed 3/2/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 5 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

02998

193

1. PLACE OF DEATH:

County..... *Howard*City or town..... *near Davis*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

4. Sex..... *M*5. Color or race..... *W*6. (a) Single, married, widowed, or divorced..... *Widowed*6. (b) Name of husband or wife..... *Ela May Funk*7. Birth date of deceased (mo., day, yr.)..... *Jan. 8, 1873*8. AGE: Years..... *72*Months..... *2*Days..... *11*

If less than one day..... hrs. min.

9. Birthplace..... *Pa.*
(Town, county, and state)10. Usual occupation..... *Farmer*

11. Industry or business.....

12. Name..... *Henry Funk*13. Birthplace..... *Ohio*14. Maiden name..... *Emily Shelby*15. Birthplace..... *Carroll Co.*16. Informant..... *Raymond Funk*Address..... *Woodbine Md.*17. Burial..... *Burial*

(Burial, cremation, or removal. Which?).....

Date thereof..... *March 22, 1945*

(month) (day) (year)

Cemetery or crematory..... *Mt. Carmel*Location..... *near Sunshine Mt., Co.*18. Funeral director..... *H. M. Snyder*Address..... *Mt. Airy Md.*19. *Mar. 21*19. *45*

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

City or town.....
(If outside city or town limits, write RURAL and give nearest town)Street No.....
(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... *March 19, 1945*..... 19..... at..... M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
March 17, 1945..... to *Mar. 19, 1945*.....and that I last saw him alive on *March 18, 1945*..... 19.....

Immediate cause of death.....

Gangrene both feet and legs..... 3 wksDue to..... *Arterio-sclerosis*..... ?

Due to.....

Other conditions..... *Chr. Myocarditis*..... ?

(Include pregnancy within 3 months of death)

Major findings of operations..... *none*

Date of op.....

Autopsy results..... *none*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... *D. Stanley Grall*Address..... *W. H. A. Co. Md.*Date signed..... *3/20/45*

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

RECEIVED

APR 6 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 129

02999

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH:

County Howard
City or town Ellicott City
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Howard
City or town Ellicott City
(If outside city or town limits, write RURAL and give nearest town)
Street No. Montgomery Road
(If rural, give LOCATION)
2.(c) If veteran, name war None

3. (a) FULL NAME

Herbert Day McKibben

3. (b) Social Security Number

217-16-0066

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Genevieve P. McKibben B.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) June 5, 1882

8. AGE: Years 62 Months 9 Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Yenia Ohio
(Town, county, and state)

10. Usual occupation Radio repair

11. Industry or business Westinghouse

12. Name Justin Harry McKibben

13. Birthplace Lima Ohio

14. Maiden name Ella Day

15. Birthplace Lima Ohio

16. Informant Mrs. Genevieve P. McKibben

Address Montgomery Road Ellicott City

17. Burial Date thereof Mar 8, 1945
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory St. Johns Cemetery

Location Ellicott City, Md

18. Funeral director Easton Sons

Address 608 Frederick Ave Catonsville, Md.

19. March 8, 1945 John B. Longman
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 5, 1945 at 1:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 3, 1945 to March 5, 1945

and that I last saw him alive on March 5, 1945

Immediate cause of death Virus Pneumonia DURATION 3 days

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations 0

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide 0 Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury 0 Injured at work? _____

23. SIGNATURE S. Lloyd Johnson M. D. or other _____
Address Catonsville Date signed 3-7-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 14 1945
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(32)

CERTIFICATE OF DEATH

Reg. Dist. No. 13191

1. PLACE OF DEATH:

County HowardCity or town Ellicott City Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HowardCity or town Ellicott City Rural
(If outside city or town limits, write RURAL and give nearest town)Street No. Wetzel Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

William Ready

3. (b) Social Security Number

4. Sex

m

5. Color or race

C

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

Angerona Ready

7. Birth date of deceased (mo., day, yr.)

Aug. 1847

8. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

97

hrs.

min.

9. Birthplace

North Carolina
(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

FATHER

12. Name

Wm Ready

13. Birthplace

NC

MOTHER

14. Maiden name

unknown

15. Birthplace

"

16. Informant

Mrs. Gus. Rogers

Address

Ellicott City Md.17. Buried

(Burial, cremation, or removal. Which?)

Date thereof

4-3-1945
(month) (day) (year)

Cemetery or crematory

Pine Orchard

Location

Pine Orchard Md.

18. Funeral director

F.C. Hegins

Address

Ellicott City Md.

19.

4-3-1945

(Date rec'd by registrar)

John B. Longman

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

March 31 1945 at 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3/1 1945 to 3/31 1945

and that I last saw him alive on

3/31/45

Immediate cause of death

Arteriosclerotic Cardio-Vascular Disease

DURATION

5 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

none

Date of op.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

George E. Bay

M. D. or other

Address

Ellicott City Md.

Date signed

3/31/45

RECEIVED

CERTIFICATE OF DEATH

RECEIVED

RECEIVED

RECEIVED
APR 26 1945
BUREAU V.S.